BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MELANIE K. KOHOUT, M.D.** Holder of License No. 23105 For the Practice of Medicine In the State of Arizona.	Case No. MD-05-1015A **CONSENT AGREEMENT FOR SURRENDER OF LICENSE**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Melanie K. Kohout, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that she has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Melanie Kohout Dated: 13 Mar 07

MELANIE K. KOHOUT, M.D.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 23105 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-1015A after receiving a complaint regarding Respondent's care and treatment of a three and a half year-old male patient ("TM").

4. On May 14, 2003, TM presented with his mother to Respondent complaining of overactiveness, aggressiveness, self-injury, mood changes, obsessive behavior and temper rages. TM's mother reported they moved to Arizona five months earlier, they had no contact with TM's father and she has a history of bipolar disorder, obsessive compulsive disorder and panic disorder. Respondent evaluated TM and diagnosed him with Bipolar disorder, severe Attentive Deficient Hyperactive Disorder, Obsessive Compulsive Disorder, Oppositional Defiant Disorder and Expressive Language Disorder. Respondent noted TM has significant stressors; he is significantly impaired and is a danger to himself or others. Respondent prescribed 2.5 to 7.5 mg of Dexedrine three times a day for TM's ADHD and 3 to 9 mg of Melatonin at night as a sleep aid.

5. On May 16, 2003, TM's mother sent an e-mail to Respondent suggesting TM had improved in some areas, but not in others. Respondent discontinued TM's Dexedrine and without physically examining him, provided TM's mother with samples of Zyprexa, an antipsychotic medication. On May 19, 2003, Respondent prescribed 2.5 mg of Zyprexa with one refill to TM's medication regimen.

6. On July 2, 2003, TM presented with his mother to Respondent for an office visit. Respondent noted TM was aggressive and increased his Zyprexa to 7.5 mg per day.

On July 21, 2003, TM's mother contacted Respondent complaining TM was not sleeping through the night and is aggressive. Without physically examining TM, Respondent increased TM's Zyprexa to 12.5 mg per day.

7. On August 12, 2003, TM and his mother presented to Respondent. Respondent completed a questionnaire regarding TM's psychiatric progress and listed his current medication regimen. Without noting TM's pulse rate or blood pressure Respondent prescribed 0.1 mg of Clonidine for hypertension. Respondent also discontinued the Zyprexa and prescribed 1 mg of Risperdal, an antipsychotic medication. Respondent provided instructions to TM's mother to assess TM's outcome and increase the Risperdal to 1.5 mg twice a day if TM's aggression continued.

8. On October 22, 2003, TM presented with his mother to Respondent. Respondent increased TM's Risperdal to 2 mg twice a day and his Clonidine to 0.3. On November 26, 2003, TM's mother contacted Respondent and reported giving TM half of her own Ambien 10 mg tablets. There is no indication in the record Respondent objected to this.

9. From December 29, 2004 to July 5, 2005, Respondent prescribed 10 mg of Ambien; 100 mg of Serzone, an antidepressant with liver abnormality concerns; Klonopin, a benzodiazepine 3 mg of Risperdal, which is considered to be the full dose for adults; 5 mg of BuSpar, an anti anxiety medication; Concerta, a stimulant medication; 100 mg of Amantadine, an antiviral medication and Lamictal for TM's mood and anxiety. Respondent also prescribed Zyrtec and Flonase for TM's allergies rather than providing a pediatrician referral. Respondent did not provide informed consent to TM's mother including TM's diagnosis, the purpose of the medications or the risks and benefits of the medications prior to prescribing the medications.

10. On April 20, 2005, TM presented with his mother to Respondent complaining of twitching and drooling. Respondent did not evaluate TM for extrapyramidal symptoms (movement disorder) that may have been caused by his medications. Respondent noted the drooling was attributed to nasal congestion and decreased TM's Risperdal to 4 mg. Respondent did not provide a referral or contact a pediatrician or TM's primary care physician regarding TM's extrapyramidal symptoms.

11. On June 14, 2005, TM's mother sent Respondent an e-mail wanting to decrease TM's Risperdal. Without physically examining TM Respondent decreased the Risperdal to 2 mg.

12. On July 3, 2005, TM presented to the emergency room with extrapyramidal symptoms that required intravenous medication to stop the reaction. The emergency room physician ("ER physician") contacted Respondent and she instructed the ER physician to write a prescription for 1 mg of Benztropine twice a day, to discontinue TM's Amantadine and to have TM come to her office as soon as possible. On July 5, 2005, Respondent's office staff noted ER physician had prescribed 0.5 mg of Benztropine twice a day and TM's mother wanted the dosage increased. Without physically examining TM Respondent prescribed 2 mg of Benztropine, ½ tablets twice a day, which is four times the range the ER physician prescribed.

13. When presented with a three and a half year-old child with multiple behavioral problems, the standard of care requires a physician to gather previous medical and educational records, obtain a complete history, perform a mental status and a brief neurological examination, collaborate with other treating physicians, develop a diagnosis and assessment plan and treat the patient conservatively based on the evaluation.

14. Respondent deviated from the standard of care because she failed to gather previous medical and educational records on TM, failed to obtain his complete history,

failed to perform a mental status and a brief neurological examination on TM, failed to collaborate with TM's other treating physicians, failed to develop a diagnosis and assessment plan and failed to treat TM conservatively based on his evaluation.

15. The standard of care requires a physician to recognize a pattern of phone calls and e-mails by a patient's mother reporting her child's symptoms and requesting medications for those symptoms and to obtain the patient's psychosocial or home situations before changing, adding, increasing or decreasing medications and set guidelines for treatment.

16. Respondent deviated from the standard of care because she failed to recognize a pattern of phone calls and e-mails by TM's mother reporting various symptoms and requesting medications for those symptoms. Respondent failed to obtain TM's psychosocial or home situation before changing, adding, increasing or decreasing his medication and she failed to set guidelines for treatment.

17. The standard of care requires a physician to contact Child Protective Services to report evidence of drug diversion between mother and child.

18. Respondent deviated from the standard of care because she failed to contact Child Protective Services to report that TM's mother provided him with her Ambien medication.

19. The standard of care requires a physician to provide informed consent, including the patient's diagnosis, the purpose of the medications or the risks and benefits of the medications prior to prescribing medications.

20. Respondent deviated from the standard of care because she failed to provide informed consent prior to prescribing medications to TM.

21. Respondent's failure to physically examine TM while administering several different medications led to TM developing an extrapyramidal reaction that required intravenous medication to stop the reaction.

22. During the investigation, Board Staff noted Respondent's medical records were incomplete and were missing information regarding TM's care. During an investigational interview, Board Staff asked Respondent if she altered any of TM's medical records. Respondent reported she had not, but later admitted altering TM's medical records when she filled out TM's patient assessment form six months after she had evaluated him. As part of the investigation, Board Staff reviewed Respondent's appointment book and TM's medical records. On September 21, 2004, May 19, 2005 and June 13, 2005, Respondent noted in the medical record that TM had not shown for appointments. This does not correspond with Respondent's appointment book indicating TM's appointment was cancelled, that the day was fully booked or that TM presented for his appointment.

23. During the investigation, Board Staff received an e-mail from the complainant indicating Respondent received a shipment of Vicodin and Alprazolam, both controlled substances, from a pharmaceutical company and dispensed those medications without a dispensing license, without performing a physical examination and without maintaining medical records. In response to the Board's investigation, Respondent admitted dispensing Vicodin to a current employee ("SF") without a dispensing license, without performing an examination on SF and without maintaining medical records on SF. Respondent also admitted to giving the Alprazolam to her dog for separation anxiety, which was not previously prescribed by a veterinarian. On May 23, 2006, Respondent brought the Vicodin and Alprazolam bottles to her investigational interview. Board Staff noted both bottles were half empty and the number of pills used was inconsistent with

Respondent's stated use indicating Respondent was using the drugs. The e-mail also indicated Respondent used SF's name to obtain prescriptions for her personal use. In her response, Respondent admitted she wrote prescriptions for Vicodin, dated April 19, 2006 under SF's name and asked SF to fill the prescription and return the pills to her.

24. In response to the Board's investigation, Respondent admitted to signing blank prescription pads and giving them to her office manager to write refills for patients in case she was not available or was with a patient.

25. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because Respondent did not note TM's pulse rate or blood pressure prior to prescribing a hypertension medication. Respondent did not maintain medical records for SF.

26. Respondent admits to the acts described above and that they constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. §32-1401(27)(f) ("[h]abitual intemperance in the use of alcohol or habitual substance abuse"); A.R.S. §32-1401(27)(g) ("[u]sing controlled substances except if prescribed by another physician for use during a prescribed course of treatment"); A.R.S. §32-1401(27)(k) ("[s]igning a blank, undated or predated prescription form"); A.R.S. §32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. §32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an

application for privileges at a health care institution"); A.R.S. §32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board"); A.R.S. §32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient"); A.R.S. §32-1401(27)(kk) ("[f]ailing to dispense drugs and devices in compliance with article 6 of this chapter") and A.R.S. §32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . .").

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. §32-1401(27)(f) ("[h]abitual intemperance in the use of alcohol or habitual substance abuse"); A.R.S. §32-1401(27)(g) ("[u]sing controlled substances except if prescribed by another physician for use during a prescribed course of treatment"); A.R.S. §32-1401(27)(k) ("[s]igning a blank, undated or predated prescription form"); A.R.S. §32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. §32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution"); A.R.S. §32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence,

including attachments, with the board"); A.R.S. §32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient"); A.R.S. §32-1401(27)(kk) ("[f]ailing to dispense drugs and devices in compliance with article 6 of this chapter") and A.R.S. §32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . .").

ORDER

IT IS HEREBY ORDERED THAT License Number 23105, issued to Melanie K. Kohout, M.D. for the practice of allopathic medicine in the State of Arizona, is surrendered and that Melanie K. Kohout, M.D. immediately return her wallet card and certificate of licensure to the Board.

DATED and effective this 12 day of April, 2007.

ARIZONA MEDICAL BOARD

(SEAL)

By: _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of April, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 13th day of April, 2007 to:

Melanie K. Kohout, M.D.
Address of Record

Investigational Review